NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Trust Headquarters
St George's Hospital
Corporation Street
Stafford
ST16 3SR

[redacted]

J.P. Ellery
Senior Coroner
HM Coroner's Services
Shirehall
Abbey Foregate
Shrewsbury
Shropshire;
SY2 6ND

2nd February 2019

Dear Mr Ellery

RE: [redacted]

Report to Prevent Future Deaths

Thank you for your letter dated 21st December 2018, reporting a matter to us, in accordance with Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

May I take this opportunity to reassure you that following [redacted] death, we undertook a thorough investigation into the care delivered by the Trust.

Following discussions within the teams involved, I am now in a position to respond to your specific concerns, where by you stated you heard at the inquest during the course of the evidence:

1. Delay in IAPT Counselling
   After [redacted] turned 18 she moved to Adult Mental Health Services. She had parallel contact with her GP surgery in [redacted] Shortly before [redacted] 18th birthday according to the MPFT Clinical Review
   (page 9 of 33), [redacted] was referred to Improving Access to Psychological Therapies (IAPT)

   by the [redacted] Access Team for assessment for psychological therapy or counselling. On 14th November 2017 (page 12 of 33) it was agreed with [redacted] to add her to her GP surgery waiting list for counselling in line with her treatment preference. [redacted] remained
   on the IAPT waiting list for counselling at the time

The evidence at the inquest was that a 3 month time interval would be optimal but in [redacted] case, in relation to this GP surgery, 10 months would be the norm. Such a delay is sub-optimal and could have an adverse effect on a patient waiting for counselling to commence.

Historically, counselling provision [redacted] has been provided from a practice-based model and commissioned from a number of providers, including IAPT. Since January 2019 the commissioning arrangements for GP counselling [redacted] have been changed, so that IAPT will in future provide all counselling provision across the county. The existing provision is person centred in orientation where the patient will be given information and then decide where they would prefer to be seen.

The revised model eligibility criteria will give the IAPT service increased capacity, enabling greater flexibility with regard to where and when people can be seen. A 3-month transitional period is currently underway during which a redesign of the IAPT service is taking place, whereby counselling provision will be more consistently provided across the county from a locality based model, which is more efficient and therefore it will be more possible to be flexible in responding to changes in supply of staff to meet changes in demand thus reducing waiting times to within the statutory 18 week target. It is anticipated that once this work is completed, planned within a six month timescale, it will then be possible to keep waiting times within these recommended limits.

2. The electronic records were hard for a lay person to follow or understand particularly when said to have been updated or validated with the potential for original entries to have been overwritten (as opposed to amended or deleted). If the user of the system understands it then that does not make it unfit for purpose but it was not clear how a user would readily see what had originally been written.

The Trust uses the Rio system for electronic patient records. It is impossible for clinicale staff to overwrite fields in Rio forms to change or delete an entry once it has been madee without the system recording this. Records of all changes can be viewed by the cliniciane through clicking on the "history" tab. When a Subject Access Request is made, oure Health Records department print out the most up to date record. The "how to guides fore the forms in Rio are currently being updated to instruct staff how to find the history ofe an entry. Where the previous versions are requested, these are printed out as secondarye notes which include the dates the changes were made unfortunately, at present the onlye way to identify what the exact change was, is to compare the 2 sets of notes. We aree currently looking at further developing the system to address this issue.e

In regard to the validation of notes, legally it is only students who must have theire records validated by a qualified member of staff. All other staff are required to validatee their own entries. The action of validating the entry represents the electronic signaturee of the accuracy and confirmation of that entry. The Trust has explored with our healthe information colleagues whether the default could be an automatic validation which ise then "unticked" but this is not achievable given that some staff must have their entriese

validated by others. We have issued a reminder to staff to validate their records and a regular audit of un-validated notes is undertaken with feedback of the audit outcome being sent to the clinical teams.

This is distinct from progress notes and/or risk assessments being accurately recorded. It was not clear when and how often risk assessments should be updated and how and when they would be read in conjunction with the progress notes. Were risk assessments intended to be summaries if a user did not have time to read all the progress notes? What function were they intended to serve? Consideration should be given as to whether the system can be improved.

Since we became a new Trust in June 2018 our services have expanded considerably leading to a review of all Trust Policies and Procedures. We are currently updating our policies and procedures for Clinical Risk Assessment and Management. The new policy will go to Trust Board in March 2019 and includes the directive that all risk assessments must be reviewed as a minimum once every six months and /or when there is any significant change in presentation. In addition, to complement the policy , we are developing a number of Standard Operating Procedures (SOPs) for specific services which includes one for mental health services and effective utilisation of the FACE risk assessment tool. The SOP describes how the FACE Tool is used to gather information about risk, both current and historical, and then to use this information in formulation which is an evidence based clinical decision making process enabling a robust risk management plan to be developed specifically addressing the individual patient's needs. This risk management plan will then be incorporated into the patient's overall care plan. Monitoring of this care plan is through the patient's progress notes. When there is a significant change in presentation the risk assessment is re-evaluated, risk management plan updated and reference made to this in the progress notes. In order to ensure that staff are competent in this process, the clinical risk management training, which is mandatory for all clinical staff to complete every 3 years, will cover the revised Standard Operating Procedures. The Standard Operating Procedure for Clinical Risk Assessment and Management in Mental Health will be ratified by Policies and Procedures Committee in March 2019.

I hope this response helps to address your concerns. However if you require any further information please do not hesitate to contact me

Yours sincerely

[redacted]

Chief Executive